

STATE OF IOWA
APPLICATION FOR SUPPLEMENTAL TERM LIFE INSURANCE
Underwritten by The Prudential Insurance Company of America
Control # 41626

Employee Statement

I have forwarded an "Evidence of Insurability" form to The Prudential Insurance Company according to the plan's Evidence of Insurability requirement. I understand that my application will be approved or denied regardless of the amount of insurance for which I am applying. I also understand that the **total current supplemental term life and the total applied for supplemental term life cannot exceed \$40,000 (\$30,000 for SPOC)**. I wish to apply for the following amount of supplemental term life insurance (check one only):

<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$20,000
<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$35,000	<input type="checkbox"/> \$40,000

☐ I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand that if I desire to increase the amount of my insurance, I may be required to furnish evidence of insurability satisfactory to The Prudential Insurance Company of America. I declare the statement above is true and understand it is the basis for determining the monthly contribution for coverage.

Employee Signature _____ **Date:** _____

Employee: After signing and dating, give this form to your Personnel Assistant.

Please refer to the Booklet Certificate for all plan details, including any exclusions, limitations and restrictions which may apply. Optional Term Life coverage is underwritten by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, New Jersey 07102, 1-800-524-0542. Contract provisions may vary by state. Contract Series: 83500.

Employer Statement

Employee Name: _____

Department Name: _____

Social Security Number: _____

Birth Date: _____

Employee's Current Term Life Coverage: _____

Basic ☐ \$10,000
☐ \$20,000 (UE/IUP and SPOC Only) **Supplemental \$** _____

Employer: When completed, send this form to:

**Iowa Department of Administrative Services –
Human Resources Enterprise
Group Life Insurance
Grimes State Office Building
LOCAL MAIL**